MEDICATION ORDER TO CARRY
PRESCRIBED/ OVER THE COUNTER MEDICATION

INSTRUCTIONS TO OBTAIN APPROVAL FOR A STUDENT
TO CARRY PRESCRIBED / OVER THE COUNTER MEDICATION

For online forms: *http://sbo.nn.k12.va.us/healthservices/medications.html*

These requests are exceptions to School Board policy JLCD and must be approved.

1. ***Parents will submit the following forms****:*
   - ***a.*** ***Request for Approval for Students to Carry Prescribed Medication*** *(completed by parent)*
   - ***b.*** ***Responsibilities of Student and Parent Requesting Exception to Category BSC and BESO in the Rights and Responsibilities Handbook (Category BSC: Behaviors that Present a Safety Concern and Category BESO: Behaviors that Endanger Self or Others.)***
   - ***c.*** ***Medication Release of Liability form***
   - ***d.*** ***Medication Order*** *(signed by the medical provider and must indicate the student needs to carry at all times)*

   All forms must be in order and signed.

2. *The principal will be advised of the request and determine if there are any circumstances which interfere with the approval of the request.*

3. *The school nurse will complete an Emergency Care Health Plan as appropriate.*

4. *The Registered Nurse (School Nurse) will review the request and contact the prescribing physician if indicated.*

5. *The Health Services supervisor and the school medical advisor will be contacted if there are any questions about approval.*

6. *Parents of students who will self- administer medication should contact the school nurse. The school nurse will discuss safety precautions, as indicated, with the principal, parents, student, teachers and other school personnel regarding students who carry prescribed medication. Students who carry any medication should be trained how to administer it and understand when to seek assistance. The registered nurse may require a demonstration.*

7. *The parents will sign a form assuming full responsibility and releasing the school of liability.*

8. *The school's registered nurse and principal will sign approving the request.*

9. *Approval will be effective only for the school year (including summer school) in which it is signed and must be renewed annually.*

NEWPORT NEWS PUBLIC SCHOOLS
Health Services
12465 Warwick Boulevard, Newport News, VA 23606-3041 ▪ phone: 757-591-4646 ▪ fax: 757-595-2017

REQUEST FOR APPROVAL FOR STUDENT TO CARRY PRESCRIBED/ OVER THE COUNTER MEDICATION

(<u>This form is to be completed by the parent</u>. The medical provider must complete the appropriate medication order. (Please use the appropriate request: Asthma for inhalers, Epi pen for severe allergies, or other medications)
For online forms: *http://sbo.nn.k12.va.us/healthservices/medications.html*

Name of Student: _____ *Birth date:* _____

Home Address: _____

Name of Parent(s): _____

Medication to be carried: _____

Reason student needs to carry: _____

_____

Additional information: _____

I request my son/daughter to carry the above-prescribed medication. I assume responsibility for its use at school, and transportation to and from school. I release the school from liability should reactions result from this medication. ***A medical provider has completed the necessary parts of this packet and agrees that my child needs to carry this medication and understands how to use it.*** *I understand this request is for the current school year only.*

_____ _____
Parent's Signature *Date*

Attached and completed: (All must be reviewed by RN)
___ *Signed order from Medical Provider that student is trained and able to carry*
___ *Parent signature to request*
___ *Exception to Categories BSC and BESO (parent and student signed)*
___ *Medical Release of Liability*

Notes:_____
_____
_____

Approved for current school year:
_____*, RN* _____
School Nurse *Date*

_____ _____
Principal *Date*

R-04/24

NEWPORT NEWS PUBLIC SCHOOLS

Health Services
12465 Warwick Boulevard, Newport News, VA 23606-3041 ▪ phone: 757-591-4646 ▪ fax: 757-595-2017

RESPONSIBILITIES OF STUDENT AND PARENT REQUESTING EXCEPTION TO CATEGORY BSC (Over the counter medications) AND CATEGORY BESO (Prescription medications)

(Request to Carry Prescribed/Over the Counter Medication on One's Person)

I request my son/daughter _____carry the following prescribed medication: _____.

I have read Category BSC and Category BESO which state:

> ***Category BSC****: Drugs: Violating school board non-prescription medication policy and look-alike drug policy. Alcohol: Distributing alcohol to other students. Drugs: Possessing drug paraphernalia*
>
> ***Category BESO****: Drugs: Possessing controlled substances, illegal drugs, inhalants, synthetic hallucinogens, or unauthorized prescription medications. Drugs: Being under the influence of controlled substances, illegal drugs, inhalants, synthetic hallucinogens, or unauthorized prescription medications Drugs: Using controlled substances or using illegal drugs or synthetic hallucinogens or unauthorized prescription medications. Drugs: Distributing controlled substances or prescription medications or illegal drugs or synthetic hallucinogens or alcohol to other students.*

I understand that approval of this request does not release my son/daughter from penalty if he/she misuses this exception. For example: knowingly taking medication improperly, giving medication to another student, or failing to report another student who tries or is suspected of trying to gain access to the medication.

I understand the penalties for misuse of this exception will result in student discipline equal to those violations of Levels 3-5, including a short-term removal from to school to long-term suspension or expulsion.

I have read, reviewed and explained this information to my son/daughter. We understand the rules and penalties for misuse of this exception. We acknowledge the responsibilities incurred by the granting of this exception.

Signed_____ (Parent) Date: _____

Signed_____ (Student) Date: _____

R-04/24

NEWPORT NEWS PUBLIC SCHOOLS
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MEDICATION RELEASE OF LIABILITY FORM

Student: _____ School: _____ Grade: _____

Address: _____

Parent/Guardian: _____ Phone: #_____
(Home)

_____ Phone: #_____
(Work)

TO AUTHORIZED SCHOOL PERSONNEL:

In case of_____

I hereby request and authorize you to assist and/or give

_____
(Dose and Medication)

to: _____, as prescribed by
(Student's Name)

_____. I release school personnel from liability
(Medical Provider's Name)

should reactions result from this medication, whether self-administered by my child or given by school personnel. If possible, I prefer follow-up care and transportation as follows:

_____

_____

_____ _____
Parent/Guardian Signature Date

R-04/24

NEWPORT NEWS PUBLIC SCHOOLS
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MEDICATION ORDER

For online forms: ***http://sbo.nn.k12.va.us/healthservices/medications.html***

It is best if students can take medication at home. When this is not possible, Newport News Public Schools will cooperate in the administration of medication during school hours. **These procedures must be followed for all prescription medications, all over the counter drugs & supplements and herbal remedies.**

1. Written orders for **current school year only**, from a medical provider, detailing the name of the drug, dosage and time interval medication is to be taken must be on file. Medication ordered 3 times a day or less cannot be given without a specific time. Orders should specify a time since lunch time can be anywhere from 10:30 am to 1:00 pm.

2. The signature of parent or guardian requesting that the school division comply with the physician's order is required. Medication will be given by the school nurse or school personnel designated by the principal.

3. Medication must be brought to school by the parent or guardian in a container appropriately labeled by the pharmacy or medical provider. Bring only that amount of medication to be taken during school hours. Extra medication must be picked up by a parent. Advil, Tylenol, and other over the counter medicines must be handled the same as prescription drugs and be in an original container. Expired drugs will not be given.

Please complete and sign this form (*Medical Providers are asked to complete the Asthma Action Plan on the reverse side of this form for students with Asthma)*:

Name of Child: _____

Diagnosis: _____

Date of Order: _____

Name of Medication: _____

Dosage: _____Time: _____

Duration of Order: _____

(Duration cannot exceed current school year.)

Comments: _____

_____ Student needs to carry this medication on his/her person at all times, has been trained by medical provider on how to use, and understands when to seek assistance.

Medical Provider's Signature: _____

Print: _____ Phone Number: _____

I request that the school give the above medications as ordered by the provider. I give permission for the school nurse to contact the medical provider if indicated to carry out this order.

_____ _____

School Student Attends Parent or Guardian

R-4/24